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| {F 000} | INITIAL COMMENTS | {F 000} | | |

This visit was the 23 day Revisit to the Complaint survey exited on November 26, 2014 with Immediate Jeopardy not removed at F314.

The Immediate Jeopardy has been removed.

Survey Date: December 15, 2014

Facility Number: 000195
Provider Number: 155298
AIM Number: 100267690

Survey Team:
Mary Jane G. Fischer RN TC
Tammy Alley RN

Census Bed Type:
SNF/NF: 69
Total: 69

Census Payor Type:
Medicare: 15
Medicaid: 33
Other: 21
Total: 69

Sample: 5
Supplemental sample: 10

During this visit, Pyramid Point Post Acute Rehabilitation Center was found to have removed the Immediate Jeopardy deficient practice previously cited at F314 as of December 15, 2014 with the implementation of systemic correction that included an effective abatement plan which included the retraining and return demonstration of staff for: the accuracy of the admission

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| {F 000} | Continued From page 1<br>assessments, weekly skin assessments, accuracy of staging and wound measurements, notification of pressure ulcer changes, and application of appropriate preventative measures and treatments. the staff were also trained on accuracy for completion of shower sheets, proper communication requirements, with continued staff training for incontinent residents with return demonstration and competencies validated.<br><br>The noncompliance remained at the lower scope and severity level of pattern with no actual harm but potential for more than minimal harm that is not Immediate Jeopardy.<br><br>This visit only reviewed the noncompliance cited at Immediate Jeopardy in the November 26, 2014 visit.<br><br>This deficiency reflects State finding in accordance with 410 IAC 16.2-3.1<br><br>Quality Review was completed by Tammy Alley RN on December 18, 2014. | {F 000} | | |
| {F 314} SS=J | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | {F 314} | | |

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| {F 314} | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure when a resident had previously been re-admitted to the facility after a hospitalization with a Stage 1 (intact skin with non-blanchable redness) pressure ulcer, the facility failed to identify, monitor and treat the worsening of the pressure ulcer from the Stage 1 to a Stage 3 (full thickness tissue loss) and unstageable pressure ulcers (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed), (Resident E), failed to ensure prevention and treatment was provided to an acquired pressure to prevent worsening from a stage 2 to a Stage 4 (Resident F) and failed to ensure skin assessments and skin risk assessments were completed as indicated (Resident A and B) for 4 of 5 residents reviewed for pressure ulcers in sample of 5 and supplemental sample of 10.<br><br>The Immediate Jeopardy began on 11-18-14 when the facility failed to monitor and treat known Stage 1 pressure ulcers that progressed to Stage 3 and Unstageable pressure ulcers without being aware the pressure ulcers progressed to Stage 3 [full thickness tissue loss] and Unstageable and acquired pressure ulcers had worsened to a stage 4 ulcer. The Administrator and the Director of Nurses were notified of the Immediate Jeopardy at 4:20 p.m., on 11-24-14.<br><br>On the 23 day revisit, the Immediate Jeopardy was removed on 12-15-14, but the noncompliance remained at the lower scope and severity level of pattern with no actual harm but potential for more than minimal harm that is not | {F 314} | | |

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Immediate Jeopardy.

Findings include:

1. The record for Resident "E" was reviewed on 11-24-14 at 12:00 p.m. Diagnoses included, but were not limited to dementia, diabetes mellitus and hypertension. These diagnoses remained current at the time of the record review.

A review of the resident's Minimum Data Set (MDS) Assessment, dated 10-07-14 indicated the resident required extensive assistance and two+ staff members with transfer, bed mobility, and toileting, extensive assistance with 1 staff member for hygiene and dressing, was always incontinent of bowel and frequently incontinent of bladder.

A review of the Braden Scale (a measurement to determine a resident's risk of pressure ulcers), dated 11-19-14 indicated this dependent resident was at "moderate risk."

A review of the resident's plan of care, originally dated 10-19-12 and currently dated through 10-2014, indicated the resident had the potential for impaired skin integrity related to "impaired mobility, cognitive deficit's, incontinence and terminal/end stage disease."

Interventions to this plan of care included "pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm [morning and evening] care, maintain HOB [head of bed] in lowest possible position, notify MD [medical doctor] promptly of skin breakdown, refer to RD [registered dietitian]

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PRN [as needed] to evaluate diet/needs, bathe/shower per schedule, monitor incontinence, provide peri-care, and evaluate skin weekly."

The resident's record indicated the resident had previously been an "inpatient" at a local area hospital and upon "readmission," on 11-12-14, was identified as alert to person and place, was dependent for bathing, eating, toileting and bed mobility, a Stage one pressure ulcer to the right buttocks with interventions which included pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management." The physician ordered the treatment of Calmoseptine to the affected area.

A review of the nurses progress notes, dated 11-13-14 at 5:00 p.m., indicated the following: "Writer received call from dialysis stating 'resident had fell off stretcher during transport from dialysis. Resident had small abrasions at forehead but refused to go to ER [emergency room] for evaluation. Spoke with [name of individual] who reported that resident appeared OK with no complaints and EMT [emergency medical technicians] applied neck brace. Writer informed dialysis to send resident back to facility and informed DON [Director of Nurses] of incident.'"

"11-13-14 at 5:30 p.m., Resident returned to unit via stretcher and 2 attendants, noted neck brace and resident eyes open. C/O [complains of] 'little back pain.' Nurse Practitioner at facility and requested EMT to send resident to [name of local area hospital] ER for evaluation and treatment."

"11-13-14 at 10:00 p.m., Writer <sic> called [name of local area hospital] for update and

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resident admitted for subdural hematoma due to transporting resident from dialysis and stretcher hit broken concrete and resident fell. Supervisor notified."

The record indicated the resident returned to the facility on 11-14-14.

A review of the hospital "transfer" note, lacked any documentation the resident had any pressure areas. The transfer notes lacked any instruction of preventative treatment for the previously identified Stage 1 (intact skin with non blanchable redness) pressure area to the buttock and the facility nursing staff failed to assess the resident upon return to the facility.

A review of the facility "skilled documentation flow sheet," dated 11-15-14, lacked documentation of any "special care needs" which included preventative skin care, pressure ulcer care or other skin problems."

The "skilled documentation flow sheet," dated 11-16-14, indicated the resident "needs" included "ostomy or stoma care and preventative skin care."

Further review of the "skilled documentation flow sheets," dated 11-17-14, 11-18-14, 11-19-14, 11-20-14, 11-21-14, 11-22-14 and 11-23-14, continued to indicate the need for "preventative skin care."

A review of the "Weekly Skin Assessment - Licensed Nurse to Complete," dated 11-17-14, indicated the resident had "no red or open areas, no tenting and mucous membranes were moist."

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A review of the Shower Sheets, dated 11-13-14, indicated the resident received a "bed bath" with no documentation of skin concerns. The Shower Sheet dated 11-15-14, also lacked documentation of skin concerns. No additional Shower sheets were provided for review.

A review of the "Flow Sheet," for November 2014, indicated the resident received a bed bath on 11-16-14, 11-17-14 and 11-21-14, with no documentation of skin concerns.

During an observation on 11-24-14 at 8:40 a.m., the resident was observed lying in bed on his back.

An additional observation on 11-24-14 at 11:40 a.m., the resident was observed on his back. Upon entrance to the resident room, a pungent odor permeated the room.

A request was made to perform a skin assessment and Licensed Nurse #6, requested permission of the resident, however the resident appeared unresponsive and unable to respond.

The licensed nurse instructed the resident of the need to perform a body assessment. The resident did not respond. The licensed nurse indicated the resident was "usually not like this and before a previous hospitalization was able to respond, but I haven't been here for a couple of days."

The licensed nurse again instructed the resident that she would turn him to his side in order to perform a body assessment.

The licensed nurse pulled the bed linens down to

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the resident's knees and then in one movement turned the resident to his left side. The resident's incontinent brief was untaped along both sides and the incontinent brief was pulled down to the resident's thighs.

The incontinent brief was soiled with stool. The resident's bilateral buttocks were observed with bilateral pressure areas along the right, left buttocks and coccyx area and a large area was covered with a dried thick cracked pink substance. The licensed nurse indicate she was unaware of the pressure areas and indicated she would "need to contact the wound care nurse."

The licensed nurse reapplied and taped the soiled incontinent brief on to the resident and turned the resident in order for the resident to lay on his back. The licensed nurse indicated the wound care nurse was currently on her "lunch break and as soon as she returns I'll get her to look at the pressure areas."

On 11-24-14 at 12:35 p.m., the resident remained on his back with the soiled brief.

On 11-24-14 at 12:50 p.m., the resident remained on his back, when the wound care nurse came to the resident's room.

During interview on 11-24-14 at 12:15 p.m., the wound care nurse indicated the resident returned from the "hospital with a Stage 1 pressure ulcer. We don't follow or measure the Stage 1 pressure ulcers because the floor nurses do a skin check weekly and the CNA's [certified nurses aide] complete a shower sheet two times a week, that way the resident's skin is checked three times a week."

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The licensed nurse requested the assistance of CNA #9 and the resident was turned to his left side. The resident's incontinent brief was "untaped," and the resident's bilateral buttocks were observed.

The wound care nurse indicated the "pink dried lotion is calmoseptine. It's used to treat the Stage 1 pressure ulcers."

A review of the Resident Treatment Administration Record for November 2014, indicated "apply calmoseptine to buttocks q [every] shift and PRN [as needed] for prevention 11:00 p.m. - 7:00 a.m.. The treatment record indicated the last time the resident received the Calmoseptine treatment was 11-22-14 on night shift and lacked documentation the resident received the treatment as ordered by the physician "every shift and PRN."

The licensed nurse indicated the following assessment of the resident's buttocks:

"Right buttocks measures 2.9 centimeters in length by 2.5 centimeters in width with a moderate amount of sero-sanguineous drainage with 50 % of eschar (tan, brown or black), 25% of slough and 25% of red granulation, and unstageable."

"Left buttocks measures 4.0 centimeters in length by 2.5 centimeters in width, with 75 % of yellow slough and 25 % of red granulation tissue. It's a Stage 3 [full thickness tissue loss] pressure ulcer."

"Coccyx - it's a stage two pressure ulcer (partial

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thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) with 100 % epithelial tissue and measures 1.5 centimeters in length by .5 centimeters in width by less that 0.1 in depth."

A request was made to perform incontinent care for the resident in order to better observe the pressure ulcers. The licensed nurse obtained two wash cloths. One wash cloth was wet and the other wash cloth was dry. The nurse cleaned the resident's bilateral buttocks of stool and then indicated she needed to "re-measure" the resident's pressure ulcer to the right buttocks since the stool had been removed.

After the nurse re-measured the area, she indicated the area measured larger than previously thought and now measured "4.5 centimeters in length by 4.0 centimeters in width."

During an interview on 11-24-14 at 2:15 p.m., the wound care nurse indicated she enlisted the knowledge of another nurse (#5) who was employee at the facility and she (#5) made the determination, the area on the resident's right buttocks, the area that was previously identified as eschar was a "deep tissue injury rather than eschar, but the rest of the assessment is the same."

During an interview on 11-24-14 at 12:50 p.m., licensed nurse #6 indicated the Calmoseptine lotion "must have been applied by the night shift "because I didn't apply it." During interview on 11-24-14 at 12:50 CNA #9 indicated "it was there when I came in this morning."

During an interview on 11-24-14 at 2:15 p.m., the

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wound care nurse indicated she contacted the physician who ordered Santyl (a treatment for debridement of pressure ulcers) for the right and left buttocks and Calmoseptine for the area on the resident's coccyx.

The wound care nurse indicated, "we didn't know it had gotten this bad. That's the problem."

During an observation on 11-25-14 at 1:00 p.m., the resident was lying on his back in bed. The resident now had a low air loss mattress in place. Beneath the resident was a sheet which had been folded three times, which impeded the purpose of the low air loss mattress.

2. The record for Resident "F" was reviewed on 11-24-14 at 3:15 p.m. Diagnoses included but were not limited to, cerebral palsy, a C6 (cervical) spinal cord injury, quadriplegia, and neurogenic bladder. At the time the resident was admitted to the facility the resident's skin was intact.

A review of the hospital discharge summary dated, 10-24-14 indicated "due to patient's medical complexity, along with decreased functional mobility and self care, this patient continues to require 24 hour RN [Registered Nurse] to ensure and prevent skin breakdown, turn q [every] two hours to prevent skin breakdown."

A review of the facility Braden Pressure Ulcer Risk assessment, dated 10-24-14, indicated the resident was at a 'moderate risk" in the development of pressure ulcers.

The assessment indicated the resident had very limited sensory perception (2), occasionally moist

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(3), chairfast (2), very limited mobility (2), adequate nutrition (3), and a potential problem for friction/shear (2).

A subsequent Braden Pressure Ulcer Risk Assessment, dated 11-25-14, all scores remained the same with the exception of "friction/shear" in which the licensed nurse indicated this area was a problem. The licensed nurse did not identify the resident's lack of mobility due to his quadriplegia.

The licensed nurse failed to recognize the residents complete limitations with mobility and the score remained as "very limited" rather that "completely immobile" due to his diagnosis. The licensed nurse continued to assess the resident at "moderate risk" for pressure ulcers although he had an acquired stage four ulcer.

A review of the resident's MDS, dated 10-31-14 indicated the resident was alert and oriented, required extensive assistance and 2 + staff members with transfers, dressing, and eating, and total care with 2+ staff members in regard to bed mobility, hygiene and toileting. The assessment indicated the resident had no pressure ulcers or skin concerns at the time of the assessment.

The record indicated the resident plan of care identified him with the potential for impaired skin integrity related to impaired mobility, requires assist with turning and repositioning - two staff members. Interventions to this plan of care included, "Notify MD promptly of skin break down, monitor incontinence, encourage to reposition as able and observe skin integrity during am/pm care."

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During an interview on 11-24-14 at 3:15 p.m., the wound care nurse indicated the resident currently had an "acquired" pressure ulcer. "When we found it on 11-02-14, it was already Stage 2 ulcer."

A review of the "change of condition" report, dated 11-02-14 indicated the area measured 0.7 cm in length by 0.7 centimeters in width and less that 0.1 centimeters in depth. A notation adjacent to these measurements indicated the area measured 1.0 centimeters in length by .5 centimeters in width. The wound care nurse measured the area the following day, 11-03-14 and indicated the area measured 1.5 centimeters in length by 1.0 centimeters in width by 1.0 centimeters in depth.

During an observation on 11-24-14 at 3:30 p.m., a request was made to observe the resident's pressure ulcer. A pungent odor permeated the resident's room.
The resident agreed to the body assessment and indicated he was concerned that he had a pressure ulcer and wanted to do everything he could to aid in the healing of the ulcer. During this observation the resident indicated that he was unable to tell if he had a bowel movement "because I can't feel anything" and he was unable to turn himself from side to side. "I have to wait for the nurses to help me."

The resident indicated he was concerned because "sometimes the nurses tell me there is not enough staff to keep me turned and sometimes they forget to change the treatment."

The wound care nurse turned the resident to his

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right side with the assistance of CNA #10. During this observation the resident had a dressing to his coccyx, which was dated 11-24-14. The wound care nurse identified the dressing as a "foam dressing with Santyl."

The wound care nurse removed the soiled dressing, and the room was filled with a decaying odor. The nurse indicated the area currently measured as a Stage 3 pressure ulcer.

After the completion of the assessment and upon exiting the resident room, CNA #10 indicated, "I knew he had one [in regard to a pressure ulcer], but I didn't know it was that bad."

A review of the Wound Care Specialist notation, dated 11-10-14 indicated the following:
"Wound right buttock is a necrotic tissue unstageable pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 4 centimeters in length by 3.5 centimeters in width by 0.2 centimeters in depth."
The Specialist indicated the resident was "non ambulatory had paralysis, bowel incontinence with an "unstageable ulcer due to significant deterioration - 100 % slough. The Wound Care Specialist ordered a ROHO [cushion] in wheelchair, an alternating pressure low air flow mattress, and to turn the resident every two hours."
The notation alerted the nursing staff the resident had a "very right risk for further skin breakdown - diligent monitoring per facility staff will be essential."

A review of the Wound Care Specialist notation, dated 11-17-14 indicated the following:

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"Alert and oriented to person, place and time, wound #1 buttocks now labeled sacrum is a necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 5 centimeters in length by 4.5 centimeters in width by 0,2 centimeters in depth. There is a small amount of sero-sanguineous drainage noted which has a mild odor. The patient reports no wound pain due to the wound being insensate. The wound bed is 76 - 100 % slough. The wound is deteriorating. Significant deterioration. Pt concerned and asking what he can do to assist wound healing. Very high risk for further skin breakdown. Diligent monitoring per facility staff will be essential."

A review of the "Pressure Ulcer Evaluation Record," dated 11-24-14 indicated the area measured 5.9 centimeters in length by 3.0 centimeters in width and 2.3 centimeters in depth. The area was assessed as a Stage 3 pressure ulcer, with moderate drainage, serosanguineous with 75 % eschar and 25% granulation."

On 11-24-14 at 3:45 p.m., the wound care nurse employed the advice from the facility physician. The physician assessed the resident's pressure ulcer and indicated, "It needs to be debrided." The resident conveyed to the physician he was aware of the odor, was not turned on a regular basis nor received the treatment to the pressure ulcer. The physician enforced the need for changing positioning and to receive the ordered treatment to the wound care nurse.

A review of the physician progress notes dated, 11-24-14 at 5:00 p.m., indicated the following: Examined wound with State Surveyor. Pt.

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| {F 314} | Continued From page 15<br>[patient] needs Santyl and turned every two hours. Stage 4 ulcer."<br><br>3. The record for Resident "A" was reviewed on 11-24-14 at 9:40 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, history of urinary tract infection, dehydration and peripheral neuropathy. These diagnoses remained current at the time of the record review.<br><br>The resident was re-admitted to the facility on 09-26-14 at 6:40 p.m., after a hospitalization. A review of the "Nursing Admission Assessment," dated 09-26-14, indicated the resident was alert to person, had shortness of breath, with no recent history of nutrition, hydration or weight issues, was dependent for bathing, toileting, bed mobility, and no pressure or reddened areas.<br><br>The assessment indicated the "Initial Skin Interventions," included "pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management."<br><br>The resident's Braden Scale Assessment, dated 09-26-14, identified the resident at "high risk" for the development of pressure ulcers.<br><br>A review of the resident's Minimum Data Set Assessment (MDS), dated 10-03-14, indicated the resident had severe cognitive impairment, required extensive assistance with bed mobility, dressing, eating, hygiene, toileting, had no pressure or reddened areas and was incontinent of bowel and bladder. The assessment indicated the resident had weight loss.<br><br>The 10-24-14 MDS assessment the resident's | {F 314} | | |

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status was the same as the assessment dated 10-03-14.

The resident had a physician order, dated 09-26-14, for Weekly Skin Assessments on Mondays. The clinical record lacked documentation of the nurses weekly skin assessments.

A review of the "Shower Sheets," completed by the CNA's (certified nurses aides), indicated the following:
"10-08-14 - redness on upper back/buttocks."
"10-11-14 - redness on upper bath/buttocks."
"10-18-14 - redness on upper backside."
"10-22-14 - backside redness."
"10-29-14 - backside redness - small area open."

A review of the "Skilled Documentation Flow Sheets," related to "Special Skin Care Needs and completed by the Licensed Nursing staff indicated the following:
"October 11, 12, 13, and 18, 2014 - preventative skin care." The flow sheets lacked awareness by the nursing staff of the redness to the resident's upper back/buttocks."

The record indicated the resident had a change in condition on 10-30-14, and was transported to the local area hospital for evaluation and treatment for suspected "seizure like activity."

A review of the "Acute Hospital Transfer Record," dated 10-30-14, indicated the resident was "dependent for transfers, ambulation, toileting, bathing, eating, and positioning. A pressure ulcer risk."

This "Transfer Record" identified a bruise to the

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left lower leg, and a scab to the left ankle."

Review of the hospital "Adult Assessment Tool - Skin," dated 10-30-14, indicated, "multiple bruises, wound to left shin/shearing, bilateral heels DTI [deep tissue injury] reddened, coccyx 2 callused areas in wound bed, reddened, blanchable, reddened."

The nursing staff failed to ensure this dependent resident received treatment and services for the noted skin breakdown, prior to being transferred to the local area hospital where the skin conditions were identified.

4. The record for Resident "B" was reviewed on 11-24-14 at 9:20 a.m. Diagnoses included, but were not limited to, failure to thrive, cerebral vascular accident with dysphagia and vascular dementia. These diagnoses remained current at the time of the record review.

The record indicated the resident's Braden Scale, dated 11-05-14 indicated the resident was not at risk for pressure ulcers.

A review of the hospital "History and Physical," dated 11-03-14, indicated the resident was admitted "with hx.[history] history of end stage renal disease, dementia, COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure presented from nursing home by [family member] for altered mental status for 1 week. She has been progressively more sleepy and has not been eating or drinking will for 1 week. Dry mouth. Problems dehydration, acute hypernatremia, acute on chronic renal failure, altered mental status.

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The record indicated that from the time of re-admission to the facility on 11-05-14 through 11-24-14, the resident continued to refuse nutrition intake.

A review of the nurses progress note, dated 11-23-14 at 7:00 p.m., indicated the resident "has been refusing meals...."

The nursing staff failed to reassess the resident for the risk of pressure ulcers, until the notification of Immediate Jeopardy on 11-24-14. A subsequent review of the Braden Scale Assessment, dated 11-25-14, did not identify the resident's nutrition as "very poor," but rather as "probably inadequate."

5. During an interview on 11-26-14 at 8:00 a.m., Licensed Nurse #13 indicated she was unfamiliar with the term "Braden Scale" or "Norton Scale." "The nurse does the weekly assessment and the CNA's do it on Shower days. It's up to the CNA's to let me know if there are any changes." When questioned if she was aware of any resident in her current assignment that had pressure ulcers or any skin concerns she indicated "No - I didn't hear anything in report."

The licensed nurse indicated if a resident was on a special mattress it was "OK" to have a turn sheet. When questioned if the sheet could be folded the nurse responded "Yes."

During an interview on 11-26-14 at 8:20 a.m., Licensed Nurse #12 indicated a "turn sheet could be folded" if a resident had a physician order for a special mattress.

When questioned about the "Braden Scale"

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assessment, the licensed nurse indicated, "the Unit Manager's do that form."

6. A review of the facility policy on 11-24-14 at 3:30 p.m., titled "Pressure Ulcer, Prevention of," and undated, indicated the following:

"Purpose: To prevent skin breakdown and development of pressure sores."

"Assessment Guidelines - may include, but are not limited to: Comorbid conditions, general condition of skin, impaired circulation pain, drugs that effect wound healing, cognitive impairment, urinary or fecal incontinence, nutritional status, hydration/fluid balance, terminal condition, weight (over/under ideal or usual body weight), bedfast, mobility status, including bed mobility, limitation in range of motion and deformities, deformities, indwelling catheter, use pressure ulcer risk assessment tools per facility procedure."

"Procedure: 1. Assessment for risk of pressure ulcer development. a. Identify high and low risk residents. 2. Assess and identify complicating conditions that may contribute to pressure ulcer development. 3. Develop care plan to eliminate or minimize risk factors. a. Nutrition, b. Nutritional supplement, c. Hydration, d. Pressure relief, e. Resistance or refusal of care. 4. Apply moisture barrier gently to dry skin. 5. Change bed linen whenever wet of soiled. 6. Keep sheets dry and free of wrinkles and debris. 7. Use appropriate support surface in the resident's bed or chair. 8. Use pressure reducing or relieving devices as necessary...10. Establish a turning and positioning schedule in bed and chair to meet the resident's needs."

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"Documentation: Documentation may include: Date, time, approaches to prevent pressure ulcer development, Preventive equipment used, Condition of the resident's skin, Physician notification when change in skin condition is observed. If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective."

The Immediate Jeopardy began on 11-18-14 when the facility failed to monitor and treat known Stage 1 pressure ulcers that progressed to Stage 3 and Unstageable pressure ulcers without being aware the pressure ulcers progressed to Stage 3 and Unstageable and an acquired stage 2 ulcer had progressed to a stage 4. The Administrator and the Director of Nurses were notified of the Immediate Jeopardy at 4:20 p.m. on 11-24-14.

The Immediate Jeopardy that began on 11-18-14 was removed on 12-15-14 during the 23 day revisit when the facility had implemented an effective abatement plan, which included the retraining of the nursing staff for accuracy of admission assessments, pressure ulcer reports, notification related to change of condition, accurate weekly skin assessments, implementation of interventions, accurate staging and wound measurements, early warning notification, accurate completion of shower sheets, proper communication, and continued training related to incontinent residents with return demonstration and competencies validated. The noncompliance remained at the lower scope and severity of pattern with no actual harm but

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| {F 314} | Continued From page 21<br>potential for more than minimal harm that is not Immediate Jeopardy. The facility was continuing ongoing education and training of all licensed and certified staff related to pressure ulcer prevention, assessment, and treatment.<br><br>This Federal tag relates to Complaint IN00159511.<br><br>3.1-40(a)(1)<br>3.1-40(a)(2) | {F 314} | | |